SPECTRUM HEALTH

History/Physical/Evaluation
HISTORY/PHYSICAL/ EVALUATION - ADULT

NOTE: This form is intended to establish a thorough and efficient History/Physical. It is encouraged to dictate this. If not dictated, this form or its equivalent must be used. Any equivalent must be labeled History and Physical at the top.

Patient Name

DOB

MRN

Physician

FIN

Patient name		Age	Sex
Date	Time	Floor/Room	
Attending		Advanced Directive? ☐ Yes ☐ No	Comfort measures only? ☐ Yes ☐ No
Resuscitation status		Next of kin (print)	Relationship to patient
Allergies/Reactions: Latex? ☐ Yes ☐ No			

HISTORY

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS (HPI)/PRIOR MANAGEMENT

PAST MEDICAL HISTORY (include duration)	PAST SURGICAL HISTORY (date/complications)	SOCIAL HISTORY
☐ No past medical history	☐ No past surgical history	Tobacco within past 12 months? ☐ Yes ☐ No
		If yes, Cessation advice given? ☐ Yes ☐ No
		Amount: Duration:
		Last use:
		Willingness to quit?
		☐ Pre-Cont. ☐ Contemplate ☐ Action
		Alcohol (duration)? Last use:
		Illicit drugs (duration)? Last use:
		Occupation:
		Sexually active? ☐ Yes ☐ No
		Marital status: ☐ M ☐ S ☐ D ☐ W
		Other

FAMILY HISTORY

Father	Siblings
Mother	Children

MEDICATIONS: List medication/dose/frequency (include prescription, over-the-counter and alternative medicines)

☐ No current prescribed or OTC medications	

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DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

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SPECTRUM HEALTH

HISTORY/PHYSICAL/ EVALUATION - ADULT *(CONTINUED)*

Patient Name

DOB

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Physician

FIN

HISTORY

☐ No significant symptoms

REVIEW OF SYSTEMS:
CHECK WHEN REVIEWED, NOTE ABNORMALITIES

GENERAL
- ☐ Fevers ____
- ☐ Chills ____
- ☐ Night sweats ____
- ☐ Fatigue ____
- ☐ Sleep Difficulties ____
- ☐ Weight +/- ____

SKIN
- ☐ Rashes ____
- ☐ Pruritus ____
- ☐ Bruising ____
- ☐ Skin cancer ____
- ☐ Other lesions ____

HEAD
- ☐ Headache ____
- ☐ Head trauma ____
- ☐ Tenderness ____
- ☐ Dizziness ____
- ☐ Syncope ____

EYES
- ☐ Visual changes ____
- ☐ Blurriness ____
- ☐ Floaters ____
- ☐ Photophobia ____
- ☐ Double vision ____
- ☐ Dry/Watery eyes ____
- ☐ Cataracts ____
- ☐ Glaucoma ____

EARS
- ☐ Hearing loss ____
- ☐ Tinnitus ____
- ☐ Vertigo ____

NOSE
- ☐ Rhinorrhea ____
- ☐ Bleeding ____
- ☐ Congestion ____

THROAT
- ☐ Bleeding gums ____
- ☐ Sore throat ____
- ☐ Dysphagia ____

NECK
- ☐ Swelling ____
- ☐ Masses ____
- ☐ Pain ____
- ☐ Stiffness ____

RESPIRATORY
- ☐ Shortness of breath ____
- ☐ Wheezing ____
- ☐ Cough ____
- ☐ Sputum/color ____
- ☐ Hemoptysis ____

CARDIOVASCULAR
- ☐ Angina ____
- ☐ Palpitations ____
- ☐ Dyspnea on exertion ____
- ☐ Orthopnea ____
- ☐ PND ____
- ☐ Edema ____

PERIPHERAL VASCULATURE
- ☐ Claudication ____
- ☐ Varicosities ____
- ☐ Leg/Foot ulcers ____

GASTROINTESTINAl
- ☐ Nausea ____
- ☐ Vomiting ____
- ☐ Hematemesis ____
- ☐ Abdominal pain ____
- ☐ Indigestion ____
- ☐ Diarrhea ____
- ☐ Hematochezia ____
- ☐ Melena ____
- ☐ Constipation ____
- ☐ Hemorrhoids ____

GENITOURINARY
- ☐ Frequency ____
- ☐ Urgency ____
- ☐ Hesitancy ____
- ☐ Polyuria ____
- ☐ Dysuria ____
- ☐ Hematuria ____
- ☐ Nocturia ____
- ☐ Incontinence ____
- ☐ Discharge ____

ENDOCRINE
- ☐ Heat/Cold intolerance ____
- ☐ Polyuria ____
- ☐ Polydipsia ____
- ☐ Polyphagia ____
- ☐ LMP ____

MUSCULOSKELETAL
- ☐ Weakness ____
- ☐ Pain ____
- ☐ Redness ____
- ☐ Swelling ____
- ☐ Joint stiffness ____

NEUROLOGIC/PSYCHIATRIC
- ☐ Sensation loss ____
- ☐ Paresthesias ____
- ☐ Motor loss ____
- ☐ Fainting spells ____
- ☐ Dizziness ____
- ☐ Seizures ____
- ☐ Anxiety ____
- ☐ Depression ____

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PHYSICAL

GENERAL ____

VITALS: BP: Lying ____/____ Standing ____/____ Heart rate ____
Temperature ____ Respiratory rate ____ O_2 saturation ____
Weight ____ Height ____

SKIN ____

LYMPH ____

HEAD ____

EYES ____

EARS ____

NOSE ____

THROAT ____

NECK ____

CHEST (lungs) ____

HEART ____

ABDOMEN ____

GENITOURINARY ____

RECTAL ____

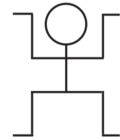
EXTREMITIES
(musculoskeletal) ____

PERIPHERAL ____

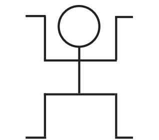
VASCULAR ____

NEUROLOGIC ____

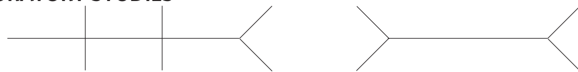
MOTOR STRENGTH



DEEP TENDON REFLEXES



LABORATORY STUDIES



STUDIES (Electrocardiogram, X-Rays, CT scans, ultrasound, echo, doppler, etc.)

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SPECTRUM HEALTH

HISTORY/PHYSICAL/ EVALUATION - ADULT *(CONTINUED)*

Patient Name

DOB

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Physician

FIN

HISTORY (CO-MORBIDITIES) ***(CONTINUED)***

PROBLEM LIST (include differential diagnosis)/**PLAN** (with respect to the problem list) Consider Physician's Orders

- ☐ **Renal Impairment:** ____________________

- ☐ **Diabetes:** ____________________

- ☐ **Cardiac Disease:** ____________________

- ☐ **Bleeding/Clotting Disorder:** ____________________

- ☐ **History of MRSA:** ____________________

- ☐ **Other As Detailed:** ____________________

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WRITTEN BY: ☐ **Intern** ☐ **Resident** ☐ **Physician Assistant** ☐ **Nurse Practitioner**

TIME	DATE	SIGNATURE	PRINTED NAME

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EVALUATION

- ***THIS FORM MUST BE COMPLETED BY THE INDIVIDUAL PERFORMING THE PROCEDURE.***

☐ **I am completing only the "Evaluation" page of this "History/Physical/Evaluation". The "History/Physical" components of this form (pages 1-3) were completed by an AUTHORIZED THIRD PARTY.**

Examination date ____________

Indications for surgery ____________

Prior management: ☐ As described in HPI ____________

____

Procedure planned ____________

Abnormal laboratory studies ____________

Imaging ____________

Physical examination (affected area): ☐ Included in the general physical examination ____________

____

____

____

Primary diagnosis ____________

____

☐ I have reviewed the comprehensive History and Physical dated ____________ and acknowledge the patient's co-morbidities. Surgeon/Proceduralist initials ____________ (required).

Plan ____________

____

Procedure Consent is to read ____________

____

Anticipated length of stay post procedure ____________

Was the patient informed of this anticipated length of stay? ☐ Yes ☐ No

Barriers to discharge plan ____________

____

The benefits and limitations of the proposed procedure, its alternatives, risks and complications were discussed with the patient (or guardian). The patient (or guardian) has voiced understanding and has consented to proceed: ☐ Yes ☐ No

TIME ____________ **DATE** ____________

Surgeon/Proceduralist signature ____________ Initials ____________

Surgeon/Proceduralist printed name ____________

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